STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004779	A. BUILDING _____ B. WING _____	06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT DUNN HOSPITAL INC	1600 23RD ST BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) licensure complaint. Date of survey: 06-20-12 Facility number: 004779 Complaint numbers: IN00104462; Substantiated: No deficiencies cited. Surveyor: Jennifer Hembree RN Public Health Nurse Surveyor St. Vincent Dunn is in compliance with 410 IAC 15-1.5-6 Nursing Services. QA: claughlin 06/28/12	S 000		